STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155329	A. BUILDING 00 B. WING	09/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT INDIANAPOLIS	1302 N LESLEY AVE INDIANAPOLIS, IN46219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for investigation of Complaints IN00096270 and IN00096460. Complaint Numbers: IN00096270 - Substantiated. Federal/State deficiency related to the allegation is cited at F309. IN00096460 - Substantiated. Federal/State deficiency related to the allegation is cited at F157. Unrelated deficiencies cited. Survey dates: September 22, 23, and 27, 2011 Facility Number: 000222 Provider Number: 155329 AIM Number: 100274950 Survey Team: Mary Jane G. Fischer RN Census Bed Type: SNF: 24 SNF/NF: 140 Total: 154 Census Payor Type: Medicare: 33	F0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review on or after October 19, 2011.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155329	A. BUILDING 00 B. WING	09/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT INDIANAPOLIS	1302 N LESLEY AVE INDIANAPOLIS, IN46219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Medicaid: 95 Other: 26 Total: 154 Sample: 6 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review 9/30/11 by Suzanne Williams, RN			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155329	A. BUILDING 00 B. WING	09/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT INDIANAPOLIS	1302 N LESLEY AVE INDIANAPOLIS, IN46219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0157 SS=D	A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on record review the facility failed to immediately inform a resident's physician when there was a change in condition, in that when a resident displayed signs and symptoms of mental status changes which included lethargy, the nursing staff failed to immediately notify the resident's physician for possible	F0157	**F157 Notify of changes (injury/decline/room)** It is the practice of this provider to ensure that all alleged violations involving notify of changes (injury/decline/room) are provided in accordance with State and Federal law through established procedures. **What corrective action(s) will be**	10/19/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155329	A. BUILDING 00 B. WING	09/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT INDIANAPOLIS	1302 N LESLEY AVE INDIANAPOLIS, IN46219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	intervention for 4 hours. This deficient practice affected of 1 of 3 residents sampled for physician notification in a sample of 6. [Resident "A"] Findings include: 1. The record for Resident "A" was reviewed on 09-22-11 at 12:45 p.m. Diagnoses included but were not limited to metabolic encephalopathy, hypertension, congestive heart failure, atrial fibrillation, chronic back pain and diabetes. These diagnoses remained current at the time of the record review. The resident had physician orders dated 08-08-11 for a Fentanyl [pain medication] 25 mcg/hr - apply 1 patch topically every 72 hours, in addition to morphine sulfate [pain medication] 30 mg ER tablet 1 by mouth two times a day, and Hydroco/Acetaminophen [pain medication] 5 - 325 1 tablet by mouth every 4 hours as needed for moderate pain. A review of the September 2011, medication administration record indicated the resident received all three medications on the morning of 09-02-11. The nurses notes indicated the following:		**taken for those residents found to have been affected by the deficient practice?** The resident no longer resides in the facility. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by this alleged deficient practice. All licensed nursing personnel will be re-educated on resident change of condition and physician notification procedures by the SDC by 10/18/11 **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** All licensed nursing personnel will be re-educated on resident change of condition and physician notification procedures by the SDC by 10/18/11 The members of the nurse manager team will audit the facility 24 hour reports daily Monday thru Friday. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** The change of condition CQI audit tool will be completed once weekly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155329	A. BUILDING 00 B. WING	09/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT INDIANAPOLIS	1302 N LESLEY AVE INDIANAPOLIS, IN46219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	"09-01-11 10:00 a.m., A/O [alert and oriented] slightly lethargic easy to arouse, speech clear able to voice needs et [and] wants to staff, pleasant, coop [cooperative] with care et meds. [medications]. Resp. [respirations] even et nonlabor <sic> no cough or shortness of breath." "09-02-11 7:00 a.m. V/S [vital signs] 124/74, p [pulse] 98, Biox [arrow pointed downward] 70 sitting in w/chair [wheelchair] in hallway. Head slumped over. Skin warm and dry. Color pale. O2 [oxygen] on at 2 L [liters] per n/c [nasal cannula]. Biox. went up to 85 when head was held up by nurse. Responds to staff but lethargic. Returned to bed. Albuterol tx. [treatment] done. Biox returned to low 90's. Will continue to monitor." "09-02-11 9:30 a.m. Biox. @ 94 on 2 liters nasal cannula. Responds to staff but immediately goes to sleep." "09-02-11 10:15 a.m. Res. [Resident] very drowsy in her room. Helped to bed. v/s 115/59, P 69, R [Respirations] 20. Resident unable to stay awake. Resting in bed with call light on. Will continue to monitor."		x4, bi-weekly x2, and then monthly thereafter by the DNS or designee. The change of condition CQI audit tools will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee. Date of Compliance 10/18/11	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155329	A. BUILDING 00 B. WING	09/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT INDIANAPOLIS	1302 N LESLEY AVE INDIANAPOLIS, IN46219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	"09-02-11 11:15 a.m. v/s 96/56, P 62. Resident still very drowsy et not able to respond to questions. NP [nurse practitioner] notified. N.O. [new order] received to give Narcan 0.2 mg IM [intramuscular] now times 1. Fentanyl patch 25 mcg applied in a.m. removed by NP." "09-02-11 11:30 a.m. Narcan IM 0.2 given times 1." "09-02-11 2:30 p.m. Speech unclear, Res. still sleepy. Skin warm and moist." A subsequent notation with the same date and time indicated the following: "09-02-11 2:30 p.m. unable to keep head upright and airway open. MD service called and order to send to ER [emergency room] at [name of local area hospital]." Review of the nurse practitioner note, dated 09-02-11 indicated the following: "Pt. [patient] was given a pain pill at the same time a new Fentanyl patch was applied. [Resident] would not wake up 1 hour later. Nurse came to get me. She would respond to sternal rub. BP [arrow pointed downward] 50's, given 0.2 Narcan IM . Change mental status probably too much medicine."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155329	A. BUILDING 00 B. WING	09/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT INDIANAPOLIS	1302 N LESLEY AVE INDIANAPOLIS, IN46219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Review of the Hospital notations dated 09-02-11 indicated "Chief Complaint: Reported to be shortness of breath, also reported a decreased level of consciousness. [Resident] was hypoxemic." 2. Review of facility policy on 09-27-11 at 8:50 a.m., titled "Resident Change of Condition," and dated as revised 03-10 [March 2010], indicated the following: "POLICY - It is the policy of this facility that all changes in resident condition will be communicated to the physician and family/responsible party, and that appropriate, timely and effective intervention occurs." "PROCEDURE - 2. Acute Medical Change. a. Any sudden or serious change in a resident's condition manifested by a marked change in physical or mental behavior will be communicated to the physician with a request for physician visit promptly and/or acute acre evaluation. The licensed nurse in charge will notify the physician." This federal deficiency relates to Complaint IN00096460. 3.1-5(a)(2)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155329	A. BUILDING 00 B. WING	09/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT INDIANAPOLIS	1302 N LESLEY AVE INDIANAPOLIS, IN46219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0225 SS=D	The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on record review and interview, the facility failed to thoroughly investigate bruising of unknown origin, for 1 of 3 residents reviewed for bruising in a	F0225	**F225 Investigat/report/allegations/individuals** It is the practice of this provider to	10/19/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155329	A. BUILDING 00 B. WING	09/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT INDIANAPOLIS	1302 N LESLEY AVE INDIANAPOLIS, IN46219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	sample of 6. [Resident "D"]. Findings include: 1. The record for Resident "D" was reviewed on 09-22-11 at 9:55 a.m. Diagnoses included but were not limited to aphasia, cerebral vascular accident, hypertension, and Parkinson's disease. These diagnoses remained current at the time of the record review. Review of the Minimum data set assessment, dated 08-12-11 indicated the resident required extensive assistance with transfers, bed mobility, dressing, hygiene and toileting. Review of the nurses notes, dated 07-19-11 at 4:00 p.m. indicated the following: "CNA [certified nurse aide] notified nurse of bruises on resident hands. Went to assess - noted a hematoma on 2nd knuckle 5 1/2 by 3 1/2 centimeters and 1 1/2 centimeters in depth on left hand, and right hand with 2 1/2 [centimeters] by 1 1/2 cm by .1 cm depth hematoma." When interviewed on 09-23-11 at 3:00 p.m., the Director of Nursing Services indicated the bruising had been investigated.		ensure that all alleged violations involving investigation/reporting/allegations/individuals are provided in accordance with State and Federal law through established procedures. **What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?** Resident D's skin was reassessed and no skin tears or bruising was identified. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by this alleged deficient practice. All licensed nursing personnel will be re-educated on resident event reporting, investigation and documentation of skin tears, bruising, and injuries by the SDC or designee by 10-18-11 The department head team will be re-educated on resident event reporting, the investigation and documentation of skin tears, bruising, unusual occurrences and injuries by the DNS/ED or designee by 10-18-11. **What measures will be put into place or what systemic changes**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155329	A. BUILDING 00 B. WING	09/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT INDIANAPOLIS	1302 N LESLEY AVE INDIANAPOLIS, IN46219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	2. Review of documentation provided by the Director of Nursing Services on 09-27-11 at 9:00 a.m., included 35 "Resident Event Investigation Questionnaires." The questionnaire included the resident's name, room number, the injury, and the date and time of event. On the reverse side of the questionnaire was a "sentence" which questioned each staff member "Do you know how the areas of bruising occurred to [resident] hands and or have you seen anything unusual with [resident] care ?" The staff interviews were conducted either in person or via telephone. The comments by the staff were inclusive to the investigation as the staff members did not know how the injury occurred. 3. The remainder of the investigative questions included "When were you assigned to care for this resident ?" "How often do you care for this resident ?" "Did you see anyone else from the staff (any department) assisting the resident or in the resident's room. If yes, who and when ?"		**will you make to ensure that the deficient practice does not recur?** All licensed nursing personnel will be re-educated resident event reporting, the investigation and documentation of skin tears, bruising, and injuries by the SDC or designee by 10-18-11 The department head team will be re-educated on resident event reporting, the investigation and documentation of skin tears, bruising, unusual occurrences and injuries by the DNS/ED or designee by 10-18-11. At the time of investigation, an additional check will be performed ensuring the investigation is complete and that the root cause analysis was also completed at this time. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** The resident event audit tool will be completed once weekly x4, bi-weekly x2, and then monthly thereafter by a facility Unit Manager or designee. The resident event audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155329	A. BUILDING 00 B. WING	09/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT INDIANAPOLIS	1302 N LESLEY AVE INDIANAPOLIS, IN46219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Did anyone from your shift help with the resident ? If yes, who." Did you see any visitor or family member in the room during your shift ?" "Who cared for the resident while you where <sic> on break ?" "When you were caring for the resident do you remember the resident bumping or hitting a part of their body ? Did anything occur that may have been construed by the resident or witness as intentional, abusive or neglectful ?" "Has the resident been out of the facility recently ?" "List any information, which will help determine what happened." "Do you have any idea of how this injury/allegation of abuse/neglect may have occurred ?" "In your own words, tell me or write down exactly <sic>happened with this resident to the best of your knowledge." "If you did not know the cause of the injury, did you ask the resident what happened ?"		Date of Compliance 10/18/11	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155329	A. BUILDING 00 B. WING	09/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT INDIANAPOLIS	1302 N LESLEY AVE INDIANAPOLIS, IN46219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	"If first aid administered at the time the injury was assessed ? if so what ?" "MD [Medical Doctor] notified, date/time." "Family notified, date/time." ED/DNS notified date/time." ISDH notified date/time." APS notified date/time." Ombudsman notified date/time." All above questions were blank for each staff member interviewed. 3.1-28(d)			
F0226 SS=D	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to implement their abuse prevention policy and thoroughly investigate bruising of unknown origin, in that when a resident was observed with bilateral bruising to the hands, the facility failed to thoroughly investigate the bruising of unknown origin, for 1 of 3 residents reviewed for bruising in a sample of 6. [Resident "D"]. Findings include:	F0226	**F226 Notify of changes (injury/decline/room)** It is the practice of this provider to ensure that all alleged violations involving develop/implement abuse/neglect, and abuse of residents and misappropriation of resident property are provided in accordance with State and Federal law through established procedures. **What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?**	10/19/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155329	A. BUILDING 00 B. WING	09/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT INDIANAPOLIS	1302 N LESLEY AVE INDIANAPOLIS, IN46219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	1. The record for Resident "D" was reviewed on 09-22-11 at 9:55 a.m. Diagnoses included but were not limited to aphasia, cerebral vascular accident, hypertension, and Parkinson's disease. These diagnoses remained current at the time of the record review. Review of the Minimum data set assessment, dated 08-12-11 indicated the resident required extensive assistance with transfers, bed mobility, dressing, hygiene and toileting. Review of the nurses notes, dated 07-19-11 at 4:00 p.m. indicated the following: "CNA [certified nurse aide] notified nurse of bruises on resident hands. Went to assess - noted a hematoma on 2nd knuckle 5 1/2 by 3 1/2 centimeters and 1 1/2 centimeters in depth on left hand, and right hand with 2 1/2 [centimeters] by 1 1/2 cm by .1 cm depth hematoma." When interviewed on 09-23-11 at 3:00 p.m., the Director of Nursing Services indicated the bruising had been investigated. 2. Review of documentation provided by the Director of Nursing Services on		Resident D's skin was reassessed and no skin tears or bruising were identified. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by this alleged deficient practice. All nursing personnel will be re-educated on abuse, resident event reporting, investigation and documentation of skin tears, bruising, and injuries by the SDC or designee by 10-18-11 The department head team will be re-educated on abuse, resident event reporting, the investigation and documentation of skin tears, bruising, unusual occurrences and injuries by the DNS/ED or designee by 10-18-11. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** All nursing personnel will be re-educated on abuse, resident event reporting, investigation and documentation of skin tears, bruising, and injuries by the SDC or designee by 10-18-11 The department head team will be re-educated on abuse, resident event reporting, the investigation and documentation of skin tears,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155329	A. BUILDING 00 B. WING	09/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT INDIANAPOLIS	1302 N LESLEY AVE INDIANAPOLIS, IN46219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	09-27-11 at 9:00 a.m., included 35 "Resident Event Investigation Questionnaires." The questionnaire included the resident's name, room number, the injury, and the date and time of event. On the reverse side of the questionnaire was a "sentence" which questioned each staff member "Do you know how the areas of bruising occurred to [resident] hands and or have you seen anything unusual with [resident] care ?" The staff interviews were conducted either in person or via telephone. The comments by the staff were inclusive to the investigation as the staff members did not know how the injury occurred. 3. The remainder of the investigative questions included "When were you assigned to care for this resident ?" "How often do you care for this resident ?" "Did you see anyone else from the staff (any department) assisting the resident or in the resident's room. If yes, who and when ?" Did anyone from your shift help with the resident ? If yes, who."		bruising, unusual occurrences and injuries by the DNS/ED or designee by 10-18-11. At the time of investigation, an additional check will be performed ensuring the investigation is complete and that the root cause analysis was also completed at this time. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** Abuse CQI audit tool will be completed once weekly x4, bi-weekly x2, and then monthly thereafter. Abuse CQI audit tools will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee. Date of Compliance 10/18/11	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155329	A. BUILDING 00 B. WING	09/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT INDIANAPOLIS	1302 N LESLEY AVE INDIANAPOLIS, IN46219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Did you see any visitor or family member in the room during your shift ?" "Who cared for the resident while you where <sic> on break ?" "When you were caring for the resident do you remember the resident bumping or hitting a part of their body ? Did anything occur that may have been construed by the resident or witness as intentional, abusive or neglectful ?" "Has the resident been out of the facility recently ?" "List any information, which will help determine what happened." "Do you have any idea of how this injury/allegation of abuse/neglect may have occurred ?" "In your own words, tell me or write down exactly <sic>happened with this resident to the best of your knowledge." "If you did not know the cause of the injury, did you ask the resident what happened ?" "If first aid administered at the time the injury was assessed ? if so what ?"			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155329	A. BUILDING 00 B. WING	09/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT INDIANAPOLIS	1302 N LESLEY AVE INDIANAPOLIS, IN46219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

"MD [Medical Doctor] notified, date/time."
"Family notified, date/time."
ED/DNS notified date/time."
ISDH notified date/time."
APS notified date/time."
Ombudsman notified date/time."

All above questions were blank for each staff member interviewed.

5. Review of the facility policy on 09-22-11 at 9:10 a.m., titled "Abuse Prohibition, Reporting and Investigation - Policy and Procedure," dated February 2010, indicated the following:

"It is the policy of American Senior Communities to protect residents from abuse including physical abuse, sexual abuse, verbal abuse, mental abuse, neglect, involuntary seclusion and misappropriation of resident property and/or funds."

"9. Residents will be questioned (if alert and competent) about the nature of the incident, and their statement will be put in writing."

"10. An investigation will be done to assure other residents have not been affected by the incident or inappropriate

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155329	A. BUILDING 00 B. WING	09/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT INDIANAPOLIS	1302 N LESLEY AVE INDIANAPOLIS, IN46219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	behavior, and the results documented." "11. The investigation will include: Facts and observation by involved employees, facts and observations by witnessing employees, facts and observations by witnessing non-employees, facts and observation from others who might have pertinent information, facts and observation by the supervisor or individual who the initial report was made." 6. Review of the policy on 09-27-11 at 12:00 p.m., titled "Resident Event Investigation," and undated, indicated the following: "Complete the Resident Event Investigation Questionnaire per established policy and procedure." "The Charge Nurse or department head must conduct a preliminary investigation and verbally report findings to the Administrator and or his designee to receive instructions on protecting the residents from further danger including suspension of involved employees. The investigation includes the following information which is to be collected upon identification of any alleged abuse/neglect:"			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155329	A. BUILDING 00 B. WING	09/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT INDIANAPOLIS	1302 N LESLEY AVE INDIANAPOLIS, IN46219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	"Obtain a narrative statement from the resident involved in the alleged event. Ask the resident what happened even if resident appears confused or has a memory deficit ... ." "Obtain statements from the staff who worked with the resident and staff person involved. Also obtain a statement in his/her own writing from the staff person involved with the alleged event. All statements must be signed, dated, and clarified that it is being obtained as part of an internal investigation. Be certain that the employee statements are clear and specific to timeframe's, events, individual observations and overall staff demeanor." 3.1-28(a)			
F0309 SS=D	Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on record review and interview, the facility failed to identify a diabetic foot ulcer, in that when a resident who had a diagnosis of diabetes, and was admitted to the facility with open areas to the lower legs, and was	F0309	**F309 Provide care/services for highest well being** It is the practice of this provider to ensure that all alleged violations involving provide care/services for highest well being are provided in accordance with State and Federal law through established procedures. **What corrective action(s) will be taken for those residents found to have been**	10/19/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155329	A. BUILDING 00 B. WING	09/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT INDIANAPOLIS	1302 N LESLEY AVE INDIANAPOLIS, IN46219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	dependent upon nursing staff for bathing and dressing, the nursing staff failed to recognize a diabetic foot ulcer and report to the physician for interventions. This deficient practice affected 1 of 3 residents reviewed for diabetic need/assessment in a sample of 6. [Resident "B"]. Findings include: The record for Resident "B" was reviewed on 09-22-11 at 2:50 p.m. Diagnoses included but were not limited to diabetes mellitus, hypertension, cerebral vascular accident, and congestive heart failure. These diagnoses remained current at the time of the record review. At the time of admission the resident was assessed with an "abrasion to right lateral calf, scabbed area to right posterior calf, discoloration to bilateral lower extremities and scabbed over scratch to left thigh." The notation		**affected by the deficient practice?** Resident B no longer resides in the facility. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by this alleged deficient practice. All residents with a dx of diabetes had a head to toe assessment completed to identify if any new ulcers were present. All licensed nursing personnel will be re-educated on the weekly skin assessments, cna skin assessments during adl care, identification of and early signs of wound development by the SDC or designee by 10-18-11 **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** All licensed nursing personnel will be re-educated on the weekly skin assessments, cna skin assessments during adl care, identification of and early signs of wound development by the SDC or designee by 10-18-11 10 random cna skin observations will be completed weekly x 4, bi-weekly x2, and then monthly thereafter by a facility Unit Manager or designee to ensure skin observations are accurate. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur,**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155329	A. BUILDING 00 B. WING	09/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT INDIANAPOLIS	1302 N LESLEY AVE INDIANAPOLIS, IN46219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	of the Interdisciplinary Team Progress note, dated 04-19-11 indicated that the areas were not "open" nor had "drainage." An Interim/Admission plan of care, dated 04-18-11 indicated the resident had the "potential for skin breakdown related to weakness, and decreased mobility." Interventions to this plan of care included, "weekly skin checks by LN [licensed nurse], CNA [certified nurse aide] to do skin check with shower and to notify LN of abnormals, right multipodus boot." Review of the Minimum data set assessment, dated 04-28-11 indicated the resident was at "risk" for skin problems, but did not have any pressure areas at the time of the assessment. In addition the resident required extensive assistance with dressing. The resident's plan of care, dated 05-02-11 indicated the resident "requires staff assist to complete		**i.e. what quality assurance program will be put into place?** A skin management CQI audit tool and will be completed once weekly x4, bi-weekly x2, and then monthly thereafter by a facility Unit Manager or designee. 10 random cna skin observations will be completed weekly x 4, bi-weekly x2, and then monthly thereafter by a facility Unit Manager or designee. The skin management CQIs and cna skin observations will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee. Date of Compliance 10/18/11	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155329	A. BUILDING 00 B. WING	09/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT INDIANAPOLIS	1302 N LESLEY AVE INDIANAPOLIS, IN46219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	daily bathing, dressing, grooming, personal hygiene and toileting due to weakness and decreased mobility." Review of the "Nutrition Risk Assessment," dated 04-18-11 indicated the resident's "skin - intact." The "Shower Report" dated 05-11-11 indicated the following: "open areas" identified on the resident's bilateral lower legs. The shower report indicated the resident "refused" the shower. The comment section indicated: "[Resident] received a bed bath and refused to shower ... told me he wants a shower tomorrow morning not tonight." The facility was unable to provide the "Shower Report" for 05-12-11. Review of the "Podiatry" progress notes, dated 05-12-11 indicated the following: "Subjective - thick painful long			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155329	A. BUILDING 00 B. WING	09/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT INDIANAPOLIS	1302 N LESLEY AVE INDIANAPOLIS, IN46219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	toenails, pain left heel. History of present illness: Admits to 2 wk [week] duration of sharp pain left heel with application of sock and shoe. No tx. [treatment] up to this point. Left posterior lateral fluid filled bulla approximately 6 centimeters in diameter, positive for pain with palpitation. Notes/orders: left bulla (wound care nurse) re [regarding] tx. plan. [Nurse] applied bunny boot to relieve pressure and granulex [illegible word].... " During an interview on 09-27-11 at 10:45 a.m., the wound care nurse employee #14 indicated the podiatrist told her about the area on the resident's foot. "[resident] had a diabetic ulcer on left heel. It was fluid filled when it started, it was on the bottom, you had to pick up [resident] leg/foot to be able to see it. [Resident] wore prevalon boots when admitted and then we added a pressure relief boot prior to the blister appearing. The heel area of the boot was hollow to help keep			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155329	A. BUILDING 00 B. WING	09/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT INDIANAPOLIS	1302 N LESLEY AVE INDIANAPOLIS, IN46219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	someone from getting ulcers. The podiatrist told me about it and we started treatment. I didn't know anything about it before that." The Weekly skin assessments dated 04-21-11, 04-25-11, 05-04-11 lacked identification of any skin concerns. However the 05-13-11 indicated the resident had a skin concern, "Left heel," on the assessment dated 05-13-11. The "Wound Skin Evaluation Report," dated 05-12-11 indicated the "wound was not present on admission, and developed on 05-12-11, with a length of 7.0 centimeters, width 6.0 centimeters and depth < 0.1." This Federal deficiency related to Complaint IN00096270. 3.1-37(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155329	A. BUILDING 00 B. WING	09/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT INDIANAPOLIS	1302 N LESLEY AVE INDIANAPOLIS, IN46219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0322 SS=D	Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. Based on record review and interview, the facility failed to provide the correct gastrostomy tube feeding formula for a diabetic resident. This deficient practice affected 1 of 3 residents reviewed for gastrostomy tube feeding and diabetic needs in a sample of 6. [Resident "B"]. Findings include: The record for Resident "B" was reviewed on 09-22-11 at 2:50 p.m. Diagnoses included but were not limited to diabetes mellitus, hypertension, cerebral vascular accident, and congestive heart failure. The resident had a gastrostomy feeding tube due to severe oropharangeal dysphasia. These diagnoses remained current at the time of the record review. Review of the Interim/Admission Nursing Care Plan, dated 04-18-11 indicated, "Resident requires tube feeding. Potential for complications. Interventions: Tube feeding diet as order, observe for tolerance."	F0322	**F322 Notify of changes (injury/decline/room)** It is the practice of this provider to ensure that all alleged violations involving, NG Treatment/Services restore eating skills are provided in accordance with State and Federal law through established procedures. **What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?** Resident B no longer resides within the facility. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents with tube feedings have the potential to be affected by this alleged deficient practice. All licensed nurses will be re-educated on verification of MD orders and the 5 rights of a medication pass in relation to the hanging of g-tube feedings by the SDC or designee by 10-18-11 Residents with feeding tubes were	10/19/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155329	A. BUILDING 00 B. WING	09/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT INDIANAPOLIS	1302 N LESLEY AVE INDIANAPOLIS, IN46219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	In addition the subsequent plan of care, dated 05-04-11 indicated the resident "relies on tube feeding to meet nutritional needs." At the time of admission, the resident had physician orders for Diabetes Boost at 80 ml [milliliters] per hour and physician orders for Accuchecks 3 times a day. The facility changed the tube feeding with a comparable formula noted as Glucerna 1.2. Review of the Dietary Progress notes, dated 05-25-11 indicated "Resident ordered for Glucerna 1.2 at 80 ml per hour to provide 2300 Kcal [kilocalorie's] - prior to admit resident was on Boost Glucose at 80 ml/hr." Review of the nurses notes, dated 05-09-11 7:00 a.m. - 3:00 p.m. indicated the following: "When came on duty noted resident had Jevity 1.2. Should've <sic>[should have] had Glucerna 1.2, change to glucerna. MD [Medical Doctor] and family notified. BS [blood sugar] [arrow pointed upward] Received 1x [one time] insulin order." Review of the "Capillary Blood Glucose		audited to ensure physician orders were followed for the correct feeding. No concerns noted. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** All licensed nurses will be re-educated on verification of MD orders and the 5 rights of a medication pass in relation to the hanging of g-tube feedings by the SDC or designee by 10-18-11 Nurses will be required to check the feeding Q shift to ensure the appropriate feeding is being administered. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** An enteral therapy CQI audit tool will be completed once weekly x4, bi-weekly x2, and then monthly thereafter by a facility Unit Manager or designee. The enteral therapy CQI audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155329	A. BUILDING 00 B. WING	09/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT INDIANAPOLIS	1302 N LESLEY AVE INDIANAPOLIS, IN46219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Monitoring Tool," dated 05-09-11 indicated the resident's blood sugar was "406 mg [milligrams] / dl [deciliter]." The record indicated the resident received 13 additional units of insulin at 12:00 p.m. During interview on 09-23-11 at 12:20 p.m., the Dietician employee #12 indicated the difference between Jevity 1.2 and Glucerna 1.2 was "the amount of carbohydrate. The Jevity 1.2 has 52 % and the Glucerna 1.2 has 35 %." During interview on 09-27-11 at 11:00 a.m., the Director of Nursing Services clarified the formula error was not noted when the nurse first arrived at 7:00 a.m., but rather around 11:00 a.m. 3.1-44(a)(2)		Date of Compliance 10/18/11	
F0323 SS=G	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure the safety of a resident, in that when a resident who was assessed as dependent upon two staff members for transfer and bed mobility, the nursing staff failed to ensure the aide protected the resident while providing care, for 1 of 3 residents	F0323	**F323 Free of accident hazards/supervision/devices** It is the practice of this provider to ensure that all alleged violations involving free of accident/hazards/supervision/devices are provided in accordance with State and Federal law through established procedures.	10/19/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155329	A. BUILDING 00 B. WING	09/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT INDIANAPOLIS	1302 N LESLEY AVE INDIANAPOLIS, IN46219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	reviewed for injury in a sample of 6. This resulted in the resident requiring hospital treatment following a fall from bed. [Resident "C"]. Findings include: The record for Resident "C" was reviewed on 09-22-11 at 11:50 a.m. Diagnoses for the resident included but were not limited to dementia with impulse control, aphasia and psychotic condition. These diagnoses remained current at the time of the record review. Review of the Minimum Data Set assessment, dated 07-07-11 indicated the resident was cognitively impaired, and required extensive assistance with transfer and bed mobility - 2+ staff members, and total assist of 1 staff member with hygiene. The siderail assessment, dated 10-09-11 indicated the resident required the use of 2 - 1/2 rails. "Use of side rails provides tactile bed boundaries for a resident with sensory deficit or poor muscle coordination, prevent accident roll out or the resident is not able to get out of bed voluntarily." The nurses notes, dated 09-19-11 at 9:45 a.m. indicated the following:		**What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?** The facility met with resident C's hospice provider and educated them on reporting to the nurses' station upon their arrival and getting the appropriate information prior to providing care to the residents. Resident C's care plan was also updated to ensure the resident is provided ADL care in bed with the assistance of 2 staff members. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by this alleged deficient practice. All nursing personnel will be re-educated on fall prevention, providing adl care in bed to dependent residents and utilization of cna sheets by the SDC or designee by 10-18-11 A meeting will be held with facility hospice providers educating them on the notification of staff of their arrival, getting report, obtaining cna sheets, and requesting facility staff assistance when providing adl care to dependant residents on or before 10-18-11 Hospice CNAs will sign in prior to providing care to residents, ensuring they receive current information regarding their patients. UM to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155329	A. BUILDING 00 B. WING	09/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT INDIANAPOLIS	1302 N LESLEY AVE INDIANAPOLIS, IN46219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

"Hospice CNA at resident's bedside providing ADL [activities of daily living] care. Alerted writer to resident, stating resident fell out of bed when rolled to left side for pericare. Writer found resident lying on stomach on side of bed with copious amounts of blood coming from facial area. 911 called r/t [related to] bleeding and multiple lacerations to face and head."

Review of the Fall Circumstance Report, dated 09-19-11 at 9:45 a.m. indicated "fall witnessed - receiving care by the Hospice Aide, laying on stomach, no clothes, resident hit head, bruises to bridge of nose, laceration to bridge of nose, forehead and hairline. Hospice aide states resident was rolled onto left side for pericare and [resident] rolled out of bed. Sent to ER [emergency room] for eval. [evaluation] and tx. [treatment]."

Review of the local area hospital facility return notation, dated 09-21-11, indicated and instructed the nursing staff as follows. "Scattered abrasions to forehead/face/bruises noted to hands. Bactroban ointment to laceration on face after cleaning with peroxide and drying."

During an observation on 09-23-11 at 9:40 a.m., the resident was observed in

monitor weekly for compliance.

What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?

All licensed nursing personnel will be re-educated on fall prevention, providing adl care in bed to dependent residents and utilization of cna sheets by the SDC or designee by 10-18-11

A meeting will be held with facility hospice providers educating them on the notification of staff of their arrival, getting report, obtaining cna sheets, and requesting facility staff assistance when providing adl care to dependant residents on or before 10-18-11

How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?

A fall management CQI audit tool will be completed once weekly x4, bi-weekly x2, and then monthly thereafter by a facility Unit Manager or designee.

The fall management CQIs will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit.

Deficiency in this practice will result

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155329	A. BUILDING 00 B. WING	09/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT INDIANAPOLIS	1302 N LESLEY AVE INDIANAPOLIS, IN46219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	bed, with side rails padded and the gastrostomy feeding infusing. The resident was observed with bilateral brownish/gray/yellow bruising to eyes, forehead, and across the bridge of the resident's nose. When interviewed on 09-23-11 at 3:00 p.m., the Director of Nursing Services indicated the Hospice aide is supposed to notify the nurse upon arrival and the facility staff would make themselves available to assist during care. Interview on 09-27-11 at 9:30 a.m., the Executive Director and Director of Nursing Services indicated a meeting was scheduled for 09-28-11 to discuss the injury sustained by the resident while under the care of the Hospice Aide, in addition this would be a part of the facility CQI [Continuous Quality Improvement] program and the inclusion of the Medical Director. 3.1-45(a)(2)		in disciplinary action up to and including termination of the responsible employee or restriction of noncompliant hospice staff. Date of Compliance 10/18/11	